SECTION 2

MEDICALLY COMPLEX CHILDREN'S WAIVER

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1 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual*.

1-1 General Policy

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, a Medicaid funded home and community based services (HCBS) waiver to eligible individuals as an alternative to facility based care. Utah's Medically Complex Children's Wavier (MCCW) was initially approved by the Centers for Medicare and Medicaid Services effective October 1, 2015. Eligibility for to the MCCW is limited to individuals who meet the targeting criteria found in Section 3-2 of this manual. Federal approval includes authorization to "waive" Medicaid comparability requirements. This allows the State to "target" Medicaid reimbursed home and community based services to a limited number of medically complex children. Additionally, the State is authorized to waive certain income and resource rules when determining eligibility for the MCCW.

The State Implementation Plan for the MCCW, approved by CMS, gives the State the authority to provide home and community services to the target group under its Medicaid plan. The State Implementation Plan and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the State Implementation Plan. To understand the full scope and requirements of the MCCW program, refer to the MCCW State Implementation Plan.

Historically, it has been necessary to admit a medically complex child into nursing facility to obtain needed services and supports. The MCCW is designed to offer individuals and their families an option to facility based care. Under the MCCW program, individuals who would otherwise require a level of care provided in a nursing facility (NF) may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Individuals enrolled in the MCCW are eligible to receive home and community based services in addition to traditional medical services covered by Medicaid.

All HCBS waiver services must comply with federal HCBS settings regulations (42 CFR § 441.301) on an ongoing basis.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid beneficiaries. This manual is not intended to provide guidance to providers for Medicaid beneficiaries enrolled in a managed care plan (MCP). A Medicaid beneficiary enrolled in an MCP (health, behavioral health or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Clients of the MCCW are specifically carved-out from receiving services through a MCP health and dental plan, but will be enrolled in behavioral health plans.

Refer to the provider manual, *Section I: General Information,* for information regarding MCPs and how to verify if a Medicaid beneficiary is enrolled in an MCP. Medicaid beneficiaries enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service beneficiaries. Please contact the MCP listed on the beneficiary's medical card for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a beneficiary enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a beneficiary's enrollment in an MCP. However, it is the provider's responsibility to verify eligibility and plan enrollment for a beneficiary before providing services. Eligibility and plan enrollment information for each beneficiary is available to providers from several sources. *Therefore, if a Medicaid beneficiary is enrolled in a plan, a fee-for-service claim will not be paid unless the claim is for a "carve-out service."*

1-3 Definitions

Definitions of terms used in general Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*). Definitions specific to the content of this manual are provided below.

Applicant: Is used to refer to the child, or the child's parent or other family member who submits the program application on the child's behalf.

Bureau of Authorization and Community Based Services (BACBS): The organizational unit within the Division of Medicaid and Health Financing that administers the MCCW program.

Client: Is used to refer to the child, or the child's parent, legal guardian or representative.

DMHF: Division of Medicaid Health Financing

Financial Management Services (FMS): Services offered in support of the self-directed services option. Financial Management Services facilitate the employment of individuals by the waiver client or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution

Home and Community Based Services (HCBS): Are Medicaid services provide through an approved 1915(c) waiver.

Medically Complex Children's Waiver (MCCW): The title of the approved 1915(c) waiver that serves eligible medically complex children.

Nursing Facility (NF): A nursing facility is the facility based service delivery alternative for MCCW clients.

Open Enrollment: Is the period during which the Department accepts waiver applications.

Self-Directed Services (SDS): Clients directly employ individuals to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining etc., of the employees.

State Implementation Plan (SIP): The State Implementation Plan for the MCCW, is approved by CMS. The SIP gives the State the authority to provide home and community services to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.

Waiver Opening: Is the availability of an individual position on the MCCW program.

2 Provider Participation Requirements

2-1 Provider Enrollment

Medicaid payment is made only to providers who are actively enrolled in the Utah Medicaid Program. Refer to provider manual, *Section I: General Information of the Utah Medicaid Provider Manual* for provider enrollment information.

In addition to completing the general provider enrollment process described in *Section I: General Information of the Utah Medicaid Provider Manual,* waiver providers are required to complete an Attachment A document to assure that providers meet the waiver specific provider qualifications.

2-2 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers and participants who have had any adverse action taken by the Utah Department of Health, DMHF, and MCCW who return a Hearing Request Form to the agency. This includes the denial of an individual's choice of provider (when more than one is available), contract reimbursement rates, sanctions, or other adverse actions related to provider performance or improper conduct of the agency in performing delegate Waiver responsibilities.

A Request for Hearing/Agency Action form (Hearing Request) is available on the Utah Medicaid website. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576. Hearing requests must be filed with the Office of Administrative Hearings within 30 calendar days from the date of the adverse action.

3 Client Eligibility Requirements

3-1 General Eligibility

MCCW services are only available to individuals who meet the program eligibility requirements and who are enrolled in the MCCW.

A Medicaid member is required to present the Medicaid Identification Card before each service, and every provider must verify each member's eligibility each time services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information,*

Verifying Medicaid Eligibility or to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

3-2 Establishing Program Eligibility

To be eligible for the program, the child must meet the following requirements at the time of application or during periodic reassessments:

1. Be 0 through 18 years of age;
2. Meet nursing facility level of care criteria as defined in R414-502-3; RN Case Managers will review documentation to verify the applicant meets nursing facility level of care as demonstrated by:
    a. Evaluation of the applicant's ability to perform age appropriate Activities of Daily Living; and
3. Have a level of disability determined by the Social Security Administration or the State Medical Review Board; and
4. Have complex chronic medical conditions and medical fragility associated with disabilities, technology dependencies, ongoing involvement of multiple subspecialty services and providers and/or frequent or prolonged hospitalizations or skilled nursing facility stays.

    a) To determine if a child has the medical complexity and intensity of services required for program eligibility, the child must have had within the last 24 months from the date of program application/review, or since the birth of the child if the child is less than 24 months old:

    i ≥ 3 organ systems affected; AND

    ii) ≥ 3 specialty physicians involved in the child's care or treatment in a comprehensive clinic with different specialty providers; AND

    iii) Prolonged dependence (> 3 months) on medical devices or treatments intended to support adequate organ function.

    iv) Meeting the established minimum Medical Acuity score from the Program Application.

4 Program Enrollment

Entrance into the program will be managed by accepting application during open enrollment periods to be determined by the Department

4-1 Open Enrollment Procedures

1. The Department accepts the following means of application during open enrollment periods:
    a. Online application, with a time and date stamp confirming that the application was received within the open enrollment period;

b. Facsimile, with a time and date stamp confirming that the application was received within the open enrollment period; and
c. Mail, with the postmark on applications dated no sooner than the first day of the open enrollment period and no later than the last day of the open enrollment period.

2. Incomplete applications, including applications in which required attachments are not submitted, will not be accepted.
3. The number of individuals who may enroll in the waiver program during an open enrollment period is based on the availability of funds.
4. If the number of applications does not exceed the number of available openings when the open enrollment period ends, the Department will enroll all individuals who meet program eligibility requirements described in *Section 3-2 Establishing Program Eligibility*.
5. If the number of applications exceeds the number of available waiver openings, the Department will prioritize entrance into the program based on the complexity of the child's medical conditions and the critical needs of the child and the child's family as identified in the *Application for Utah's Medically Complex Children's Waiver* (the Application).
    a. Applications will be ranked by Department clinical staff based on a score derived from 1) the Application that was completed and submitted by the applicant and 2) the associated required attachments: physician certification form, and a history and physical or Well Child Check summary completed by the child's physician within the last 24 months from the date of program application.
    b. Prior to enrollment into the MCCW, if Department clinical staff detect a discrepancy between the applicant's responses to the Application and the physician's responses provided on the Physician Certification Form or the history and physical or Well Child Check summary, Department staff will attempt to contact the applicant to resolve the discrepancy. To resolve the discrepancy for scoring purposes, the applicant will be required to submit written clarification from the physician. The written clarification must be submitted to the Department with a time and date stamp that confirms the discrepancy clarification document was received within 14 days from the date Department staff attempted to contact the applicant.

        i. Attempts to contact will include calling and emailing the applicant using the telephone number and email address provided in the Application. The applicant is responsible to ensure that the Department has current and up-to-date contact information.
        ii. If the applicant does not provide written clarification from the physician within the 14 day period, the lesser of the two scores for the item that is the object of the discrepancy will be used.

    c. If there are multiple applications with the same prioritized score, and the total number of same-scored applications is greater than the number of remaining waiver openings, the

Medical score will be used to select applications until all waiver openings are filled. If there are multiple applications with the same Medical Score and the total number of same-scored applications is greater than the number of remaining waiver openings, the Department will assign each application a random number and will create a randomized list. The list will be sorted based on the random number assigned to the application from least to greatest number. The Department will begin selecting applicants at the top of the randomized list and will select applications until all waiver openings are filled.

6. Entrance into the waiver is dependent on an application with the Department of Workforce Services (DWS). Once selected for enrollment, applicants will have 30 days from the date the application is selected for enrollment to apply for Medicaid with DWS or the waiver application will be denied. Applicants will be required to return the form "*Statement of Understanding*" indicating that they understand program criteria and completed application with DWS. Enrollment is determined by participant meeting financial requirements for the Medicaid program eligibility by the Department of Workforce Services.
7. If an applicant is being served in a nursing facility at the time of their application they must submit a certification from the physician indicating the client is expected to return to a community setting within 90 days. If after 90 days the client continues to be served in a facility, the department will re-evaluate the clinical condition of the applicant and may elect to hold the position for no greater than 180 days from the date the application was selected for enrollment.

4-2 Fair Hearing

DMHF provides a participant, applying for or receiving Medically Complex Children's Waiver services, an opportunity for a hearing upon written request, if the participant is:

- Not given the choice between facility-based (NF) care and MCCW services.
- Denied the Waiver provider(s) of choice if more than one provider is available to render the service(s).
- Denied, suspended, or terminated access to the Waiver program.
- Experiences a reduction, suspension, denial or termination of Waiver services identified as necessary to prevent facility placement.

A participant, or their legal representative when applicable, will receive a written Notice of Decision from MCCW if the participant is denied a choice between facility-based (NF) care and MCCW Waiver services, found ineligible for the Waiver program or denied access to the provider of choice for a covered Waiver service. The Notice of Decision delineates the participant's right to appeal the decision.

An aggrieved participant may request a hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The DMHF may reinstate services for the participant or suspend any adverse action for providers if the aggrieved participant requests a hearing not more than ten calendar days after the date of action.

The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing form and directing the request to the Department of Health, DMHF, for a hearing and determination. An informal dispute resolution process does not alter the requirements of the hearings process. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the DMHF. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for a hearing or be conducted concurrent with the hearing process.

A Request for Hearing/Agency Action form (Hearing Request) is available on the Utah Medicaid website. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576.

5 Covered Services

The MCCW offers respite services when delivered pursuant to an approved person centered care plan. Respite care is an intermittent service provided to an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in facility-based care. Respite care may be provided by a Medicaid enrolled home health agency or through the Self-Directed Service (SDS) model. For program clients, typical utilization of respite care is estimated at approximately three hours per week. Nurse case managers will conduct an assessment and develop a person centered care plan with the client to determine the type and amount of respite needed and to assist in the coordination of waiver and other services. Families will have 90 days to complete the person centered care plan once the nurse completes her assessment. In addition to waiver services, clients will have access to traditional Medicaid service coverage.

5-1 Types of Respite Services

1. *Skilled nursing respite care* coverage includes an initial RN assessment to establish a new client. Skilled nursing respite care may be provided in the home or other approved community settings.
   A. Qualified skilled nursing respite care providers include:
      i. Medicaid enrolled, licensed home health agencies that employ or contract with registered nurses, licensed practical nurses and home health aides; and are capable of providing respite care services to medically complex children in their homes and other approved community based settings.
      ii. Registered Nurses in the State of Utah under the SDS model which:
         1. Are licensed in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated 1953 as amended (records kept by FMS);
         2. Complete and pass a background and criminal investigation check annually. Annually is defined as 365 days (records kept by FMS);
         3. Are covered under an individual nursing malpractice insurance policy (records kept by FMS);
         4. Have a current basic CPR certification (records kept by FMS);
         5. Are enrolled with a FMS agency; and

6. Demonstrate the ability to perform the necessary skilled nursing functions to safely care for the client (Client is responsible for completing this function).

2. *Routine Respite Care* may be provided in the home or other approved community settings.
   A. Qualified routine respite care providers include:
      i. Agency-based providers enrolled as Medicaid HCBS waiver providers.
      ii. Individuals hired by the client under the SDS model who meet the following requirements:
         1. Complete and pass a background and criminal investigation check annually. Annually is defined as 365 days (records kept by FMS);
         2. Are enrolled with a FMS agency; and
         3. Demonstrate the ability to perform the necessary functions to safely care for the client (Client is responsible for completing this function).

5-2 Self-Directed Services (SDS)

Self-Directed Services (SDS) are made available to all waiver enrollees who elect to participate in this method. Under SDS, clients hire individual employees to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining, etc., of the individual employees.

Financial Management Services (FMS) are offered in support of the SDS option. FMS facilitate the employment of individuals by the waiver client: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.

The waiver client is the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services.

Under the SDS method, the waiver client submits their staff time sheet(s) to the FMS provider. The FMS provider pays the claims and submits a claim to the Department for reimbursement. All payments are made through the enrolled FMS provider. Payments are made directly to the employee and are not issued to the waiver client.

Financial Management Services Reimbursement

Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g., Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

6 Billing

Refer to the provider manual, *Section I: General Information*, for detailed billing instructions.

6-1 General Billing Information

Description	Procedure Code	Modifier	Provider Type
Skilled Nursing Respite	T1005	U2	58- Home Health Agency 68- Personal Care Waiver Services Agent
Routine Respite	S5150	U2	54- Personal Care Agency 58- Home Health Agency 68- Personal Care Waiver Services Agent 76- Day Treatment Facility 77-Day/ Residential Treatment Facility
Financial Management	T2040	U2	68- Personal Care Waiver Services Agent

6-2 Billing for Siblings

If it is determined by the nurse case manager during the person centered care planning process that a single respite provider may safely care for siblings enrolled in the program, the provider must bill for the approved service using the "UN" HCPCS modifier. This will allow the provider to be paid at 75% of the approved rate for both clients served. No more than two siblings may be served at one time by a single provider.

6-3 Electroinc Visit Verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1) type of service performed;
2) individual receiving the service;
3) date of the service;
4) location of service delivery;
5) individual providing the service;
6) time the service begins and ends; and
7) the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

7 Disenrollment

When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.

The disenrollment process is a coordinated effort between the MCCW Program Team and the Bureau of Authorization and Community-Based Services (BACBS) Quality Assurance Unit and is expected to facilitate the following:

- Verification that the disenrollment is appropriate for the waiver participant;
- Movement among waiver programs (when applicable);
- Ensuring effective utilization of waiver program services;
- Effective discharge and transition planning;
- Distribution of information to participants describing all applicable waiver rights; and
- Program quality assurance.

All of the various circumstances for which it is permissible for participants to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

A. Voluntary disenrollments are cases in which the participants, or their legal representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

No prior review or approval of the decision to disenroll is required from the BACBS Quality Assurance Unit.

Additional documentation will be maintained by the MCCW Program that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which the participants are involuntarily disenrolled from the waiver for any of the following reasons including:

- Death of the participant;
- Participant has been determined to no longer meet the financial requirements for the Medicaid program eligibility by the Department of Workforce Services;
- Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician)

No BACBS Quality Assurance Unit prior review or approval of the decision to disenroll is required, as the reasons for pre-approved involuntary disenrollment have already been approved. Documentation will be maintained by MCCW, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review by MCCW and a second level approval by the BACBS Quality Assurance Unit. Examples of this type of disenrollment include:

- Participant no longer meets the level of care requirements for the Waiver;
- Participant's health and safety needs cannot be met by the Waiver program's services and supports;
- Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;

The special circumstance disenrollment review process will consist of the following activities:

- The MCCW case manager shall compile information to articulate the disenrollment rationale;
- If MCCW Program Manager concurs with the recommendation, a request for disenrollment approval will be forwarded to the BACBS Quality Assurance Unit for a final decision;
- The BACBS Quality Assurance Unit will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
- MCCW and/or the BACBS Quality Assurance Unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
- The BACBS Quality Assurance Unit will communicate a final disenrollment decision to MCCW.

If the special circumstance disenrollment request is approved, MCCW or their designee will provide the participant, or their legal representative (when applicable), with the required written Notice of Decision and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

8 Incident Reporting Protocol

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community Based Services (HCBS) Waivers. Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to assure that appropriate actions have taken place when a critical incident or event occurs, and in cases when appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels: Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This Standard Operating Procedure stipulates:

- Level One incidents and events required to be reported to the SMA;
- Level Two incidents and events that are required to be reported to the OA;
- The agency responsible for completing the review; and
- Associated reporting requirements.

A. Level One Incidents and Events – Reportable to the SMA

The following list of the incidents/events must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

- **Abuse/Neglect (Either Alleged of Substantiated)**
  Incidents of abuse or neglect, that resulted in the participant's **admission to a hospital**.

- **Attempted Suicides**
  Suicide attempts that resulted in the participant's **admission to a hospital.**

- **Human Rights Violations**
  Human rights violations such as the unauthorized use of restraints (physical, mechanical or chemical), seclusion rooms or infringement of person privacy rights experienced by the participant. (Infringement of personal privacy rights as defined as an unwanted restriction imposed upon the participant). Reporting is not required for Emergency Behavioral Interventions as defined in R539-4-6.

- **Incidents Involving the Media or Referred by Elected Officials**
  Incidents that have or are anticipated to receive public attention (i.e. events covered in the media or referred by the Governor, legislators or other elected officials).

- **Medication Errors**
  Errors relating to a participant's medication that resulted in the participant's admission to a hospital.

- **Missing Persons**
  For reporting purposes, the following participants are considered to be missing:
  a. Participants who have been missing for at least twenty-four hours; or
  b. Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

- **Unexpected Deaths**
  All deaths are considered unexpected with the exception of:
  a. Participants receiving hospice care; and/or
  b. Deaths due to natural causes, general system failure or terminal/chronic health conditions.

- **Unexpected Hospitalization**
  Serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in **admission to a hospital for medical treatment.**

- **Waste, Fraud, or Abuse of Medicaid Funds**
  Incidents that involve alleged or confirmed waste, fraud or abuse of Medicaid funds by either a provider or a recipient of Medicaid services.

B. **Level Two Incidents and Events – Reportable to the OA**

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

- **Abuse/Neglect/Exploitation (Either Alleged or Substantiated)**
  Incidents of abuse or neglect, that resulted in medical treatment at a medical clinic or emergency room, or exploitation of participant's funds.

- **Attempted Suicides**
  Suicide attempts that **did not** result in the participant being admitted to a hospital.

- **Compromised Working or Living Environment**
  An event in which the participant's working or living environment (e.g. roof collapse, fire, etc.) is compromised and the participant requires evacuation**.**

- **Law Enforcement Involvement**
  Activities perpetrated by the participant resulting in charges filed by law enforcement. For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

- **Medication Errors**

Errors relating to a participant's medication which result in the participant experiencing adverse side effects requiring medical treatment at a medical clinic or emergency room.

- **Unexpected Hospitalization**

Injuries, aspiration or choking experienced by participants that resulted in **admission to a hospital**. (These do not include serious burns, self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in **admission to a hospital for medical treatment** which is reportable to the SMA).

8-1 Procedure for Reporting Fraud, Waste, or Abuse to the State Medicaid Agency

On the first business day after a critical incident has occurred, a representative from the OA will notify a participant of the SMA Quality Assurance Team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance. In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

Within ten business days after notification, the OA will submit a completed *Critical Incident Investigation* form to the SMA.

Within five business days after receiving the *Critical Incident Investigation* form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.

When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.

Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide, death and investigations that conclude with disenrollment.

8-2 Required Reports

A. OA Quarterly Report

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (January 31, April 30, July 31, and October 31) that includes:

- Name of the client
- Date of the incident

- Date the incident was reported to the OA
- Category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- Brief summary of the incident and its resolution
- Date the case was closed
- Brief description of any corrective action required of the case manager or other provider

B. OA Annual Report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

- Total number of incidents
- Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- Number of incidents that resulted in corrective action by the case manager or other provider
- Number of corrective actions that were implemented
- Number of incidents where the client/representative was informed of the investigation results, and the number of incidents where the contact was made within fourteen days of the investigation closure
- Summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps (If trends were noted, the report will include a description of the process improvement steps that will be implemented)

C. State Medicaid Agency Annual Report for Each Waiver

The SMA will submit an annual report of all reportable incidents, to the State Medicaid Director and OA Division Directors that includes:

- Number of incidents
- Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
- Number of incidents that resulted in corrective action by the OA, case manager or other provider
- Number of corrective actions that were implemented

D. State Medicaid Agency Annual Report Summary of All Waivers

The SMA will submit an annual report summarizing all reportable incidents, to the State Medicaid Director and OA Division Directors that includes:

- Number of incidents
- Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalizations should be further categorized by type
- Number of incidents that resulted in corrective action by the case manager or other provider
- Number of corrective actions that were implemented
- Summary analysis of whether any systemic trends were noticed that may require additional intervention or process improvement steps (If trends were noted, the report will include a description of the process improvement steps that will be implemented)